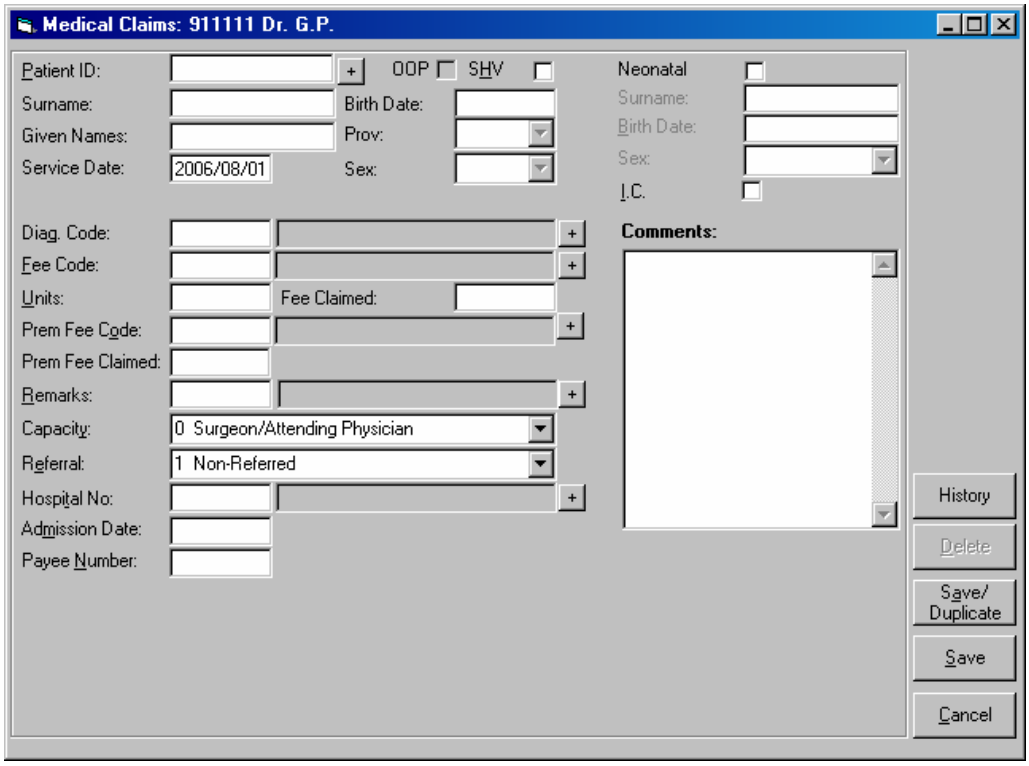
8. FEE-FOR-SERVICE CLAIMS

8.1 OVERVIEW

This section contains instructions covering the completion of fee-for-service medical claims. Shown below is a sample data entry screen for MCP's claim submission software TeleClaim 6.0. This sample screen displays all of the data elements that MCP requires for billing. Physicians using other claim completion software will notice that their claim entry screen looks different than this sample, but still contains the same data elements.

Each field on this sample has been described on the following pages. A more detailed overview of this claim entry screen may be found in the "HELP" function of TeleClaim 6.0.



- **Physician Number:** This is the physician's unique billing number, which is assigned by MCP when the physician completes the MCP registration process.

- **Physician's Name**: This is the name of the physician providing the services.

- **Patient ID**: This is the patient's MCP or Out-of-Province number. Claims submitted without

patient identity numbers cannot be processed for payment. Your office staff should remind patients to bring their cards to all appointments and should ask every patient to show his/her card upon arrival. If the patient does not provide his/her MCP card, it is the provider's option to bill that patient directly.

- **Patient Surname**: This information is not required to be submitted to MCP; however, most billing software, including TeleClaim 6.0, captures this information as an office management tool.

- **Patient Given Names**: This information is not required to be submitted to MCP; however, most billing software including TeleClaim 6.0, captures this information as an office management tool.

- **Service Date:** The date insured services were provided to the patient.

- **Birth Date**: The patient's date of birth—necessary for out-of-province patients only.

- **Province**: The patient's home province—necessary for out-of-province patients only.

- **Sex**: The gender of the patient—necessary for out-of-province patients only.

- **Diagnostic Code**: This is the diagnostic code which identifies the patient's medical condition. A list of diagnostic codes can be accessed by clicking on the "+" box to the right of the diagnostic code field in the TeleClaim 6.0. A list is also included in the Appendices section of this manual.

- **Fee Code**: This is the fee code associated with the medical service provided to the patient, as listed in the MCP Payment Schedule.

- **Units**: This is the number of units of this medical service provided to the patient. For time based services, one unit is defined as a specific time period corresponding to a specific service/procedure, as listed in the MCP Payment Schedule.

- **Fee Claimed**: This is the fee amount that corresponds to the fee code listed in the MCP Payment Schedule, with Preamble rules applied.

- **Premium Fee Code**: This is the fee code associated with service premiums, which in some instances may be claimed in addition to the fee code for the insured service. The appropriate surgical procedural premium fee codes are 01, 02, 03. These codes are listed in the MCP Payment Schedule as well as the visit premium codes 050 to 099.

- **Premium Fee Claimed**: This is the fee amount that corresponds to the visit premium fee code listed in the MCP Payment Schedule or the fee calculated for the surgical procedural

premium.

- **Remarks Code**: This code should be entered if it is necessary to make MCP aware of some pertinent information regarding the claim. Refer to Coding Systems—Remarks Codes in this section for a list of appropriate remarks codes to enter in this field. If there is no applicable fee code listed and it is necessary to convey additional information, the item must be billed "IC".

- **Capacity**: This is the capacity of the physician providing the services. The appropriate capacity codes are as follows:

  - Attending Physician/Surgeon 0
  - Surgical Assistant/Specialist Assistant 1
  - Anaesthetist 3

- **Referral Code**: In order for specialist physicians to receive the specialist rates for visit services, the patient must have been referred by another physician. The appropriate referral codes are as follows:

  - Non-referred 1
  - Referred 2

- **Hospital/Facility Number**: This is the unique hospital/facility identification number assigned by MCP. This section must be completed for all services rendered in hospitals and long term care facilities. The assigned hospital/facility numbers are listed in Appendix 3—Hospital/Facility Codes of this manual.

  General practitioners and specialists who have incentive arrangements approved for certain services rendered in hospitals will not be paid the incentive unless the proper hospital number is entered on the claim.

  General practitioners should pay particular attention to this, especially in relation to the incentive add-on to fees for services provided in rural hospitals.

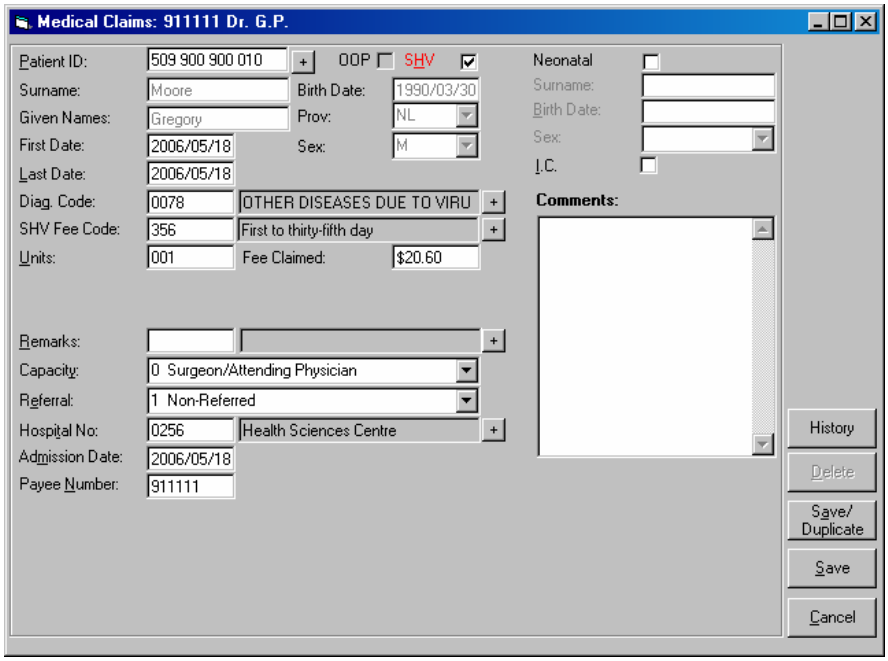
- **Admission Date**: This is the date the patient was admitted to hospital (if applicable). This date cannot be greater than the service date.

- **Payee Number**: This area indicates to whom payment will be made for the service provided. If payment is assigned to another provider or institution please ensure the payee field is completed to appropriately reflect the payee number. An Assignment of Payment Agreement must be on file at MCP if payment is assigned to another provider or institution. Please refer to Appendix 1—Forms for an example of the Assignment of Payment Agreement form.

The payee number must contain six digits. Therefore, if a three digit institution number is used as a payee number, then zeros must be added in front of three digit number to make it a six digit number, eg. institution number 999 would be entered as 000999.

- **Out-Of-Province**: This identifies the patient as a resident of another province or territory. The claim is completed in the usual manner. However, it alerts MCP to recover the amount from the patient's home province or territory.

- **Subsequent Hospital Visits (SHVs)**: When a patient is admitted to hospital, additional information is required. In TeleClaim 6.0, the following data entry screen will capture the required data. (The User must select the SHV field to display this screen.)



Other billing software will also capture the required data, although it may look different than the screen shown here.

FIRST DATE (SHV's) This is the date for which the first day of daily care is being claimed. Enter May 18, 2006 as 2006 05 18.

LAST DATE (SHV's) This will be the last SHV date billed on this claim; in most cases the date of discharge from hospital. SHV's must have a last date entered, even when only one visit is billed. (See above example.)

SHV's TYPE This code indicates the time frame during which services were provided to the patient, in relation to the patient's admission

date.

The SHV type codes are as follows:

Type Code	Fee Code	Day
2	356	1st – 35th
3	357	36th – 91st
4	358	92nd onward

VISITS-NUMBER (SHVs) This is the total number of SHVs which are being billed on this claim.

- Visit types may not be combined for billing.
- The maximum number of Type 2 visits is 35.
- The maximum number of Type 3 visits is 56.
- Only one visit type may be claimed per line.

FEE CLAIMED (SHV's) This is the total fee claimed for the SHVs on this claim. This is determined by multiplying the number of visits by the applicable per diem rate based on the visit type. For reference, an SHV table is located in the tables Section of the Payment Schedule.

- **Neonatal:** MCP has implemented arrangements whereby claims for insured services to unregistered sick newborns in the first 35 days of life may be submitted as soon as the service is rendered. Please ensure the "neonatal" field is checked for electronic claims.

  For newborns who have not yet been registered and received MCP identity cards, claims may be submitted without MCP identity numbers provided the following necessary information is submitted along with the claim. The information required is as follows:

  - mother's name, address, MCP number and telephone number
  - infant's surname, first name if known, sex and exact date of birth

- **Surname**: This is the surname of the newborn.

- **Birth Date**: This is the child's date of birth. ex. 2006 06 01.

- **Sex**: This is the newborn's gender.

- **Independent Consideration (IC)** An entry into this field alerts MCP that the claim requires manual assessment. Some items in the Payment Schedule are flagged as IC and must be

billed as IC. Also, when a service rendered is not listed in the Payment Schedule, it must be labelled IC.

If the claim is being submitted for independent consideration, an "X" must be entered in this field. Additional information supporting the claim must be entered in the "Comments" section of the claim. Failure to comply with both of these issues could result in the claim being returned to the physician.

8.2 SAMPLE CLAIMS

The following pages contain samples of completed claims for several categories of services. These are designed to illustrate the use of various fee codes used within the system and their relationship to the claim data. The physicians', patients' names, and numbers are fictitious.

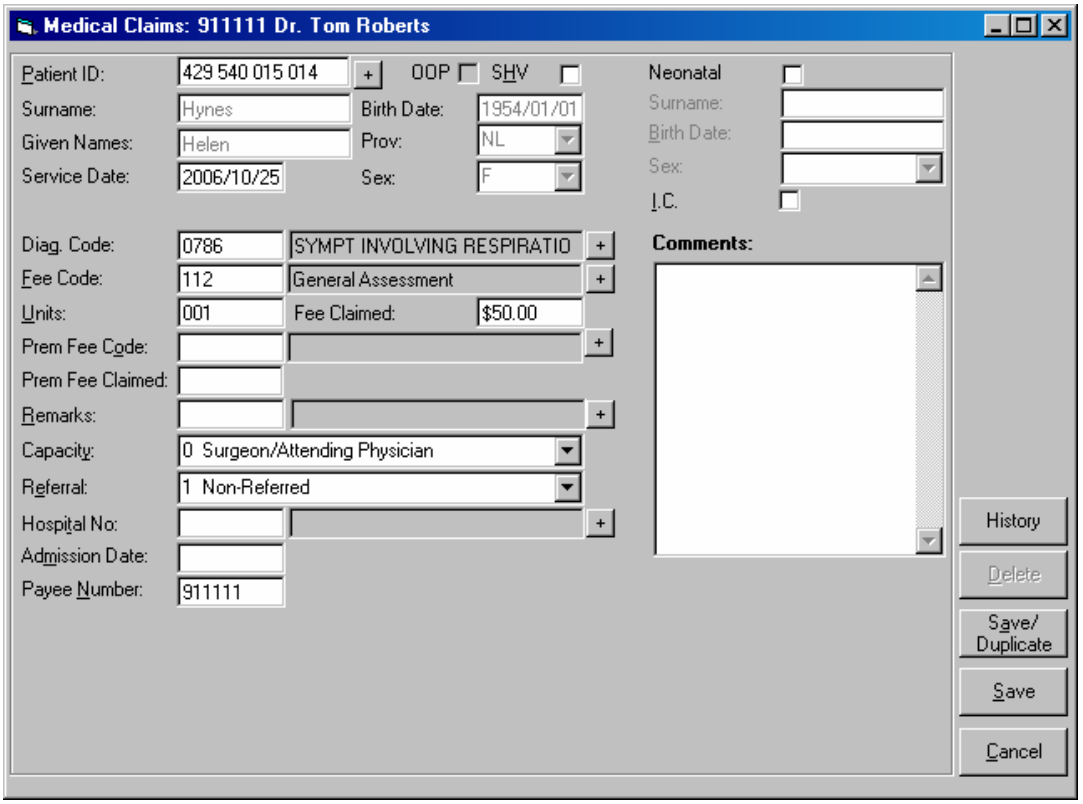
In the following cases, the fee codes and amounts may not correspond with the current Payment Schedule. Claims for services should be prepared using the latest approved schedule.

The examples are illustrated using MCP's TeleClaim 6.0. Your claims entry screen may look different if using other billing software. However, the principles of completing the claim will remain the same.

8.2.1 Case 1—General Assessment

The patient presents to her General Practitioner's clinic with chest and abdominal pain, and generalized weakness. Dr. Roberts completes a General Assessment. The fee code for a General Assessment is 112 and the corresponding fee is $50.

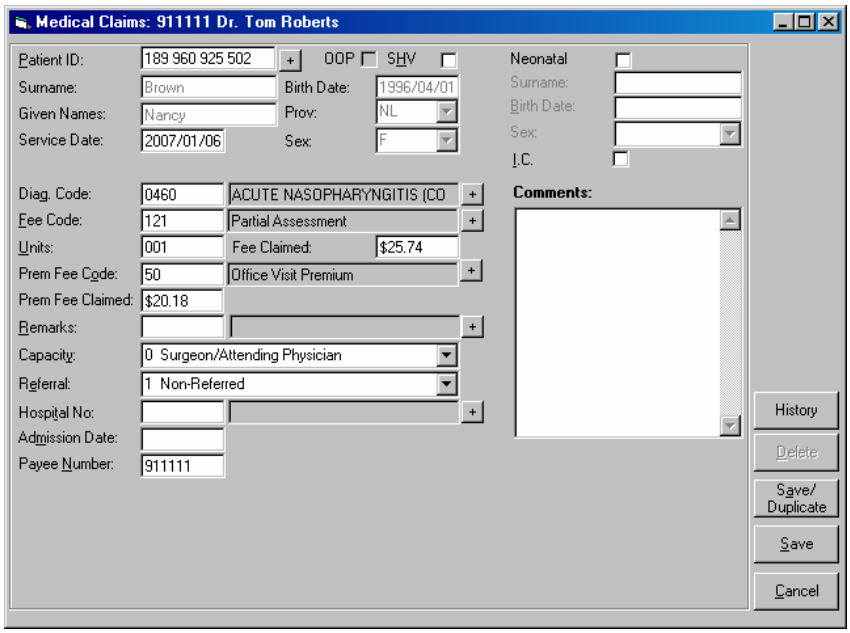
Case 1—Screen 1



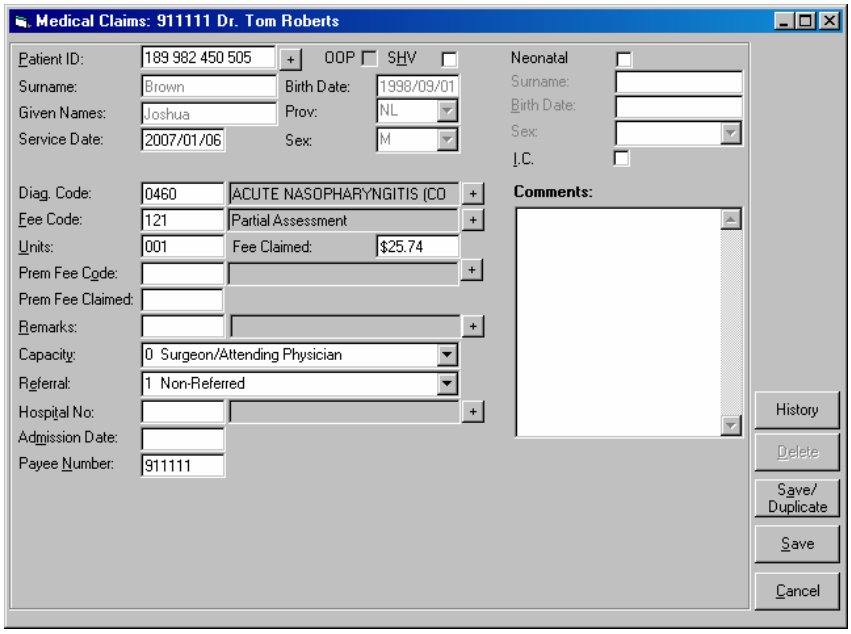
8.2.2 Case 2—Office Visit & Premium

Your secretary calls you on a Saturday morning outside your regularly scheduled office hours. A parent has asked if you would see her two children. You agree to meet them at your office. You complete a partial assessment of each child and complete your diagnosis.

Screen (1) Dr. Roberts may bill fee code 121 for a partial assessment of Nancy Brown. In addition the physician may bill an office visit premium for the first patient seen.



Screen (2) Dr. Roberts bills fee code 121 for a partial assessment of Joshua Brown.

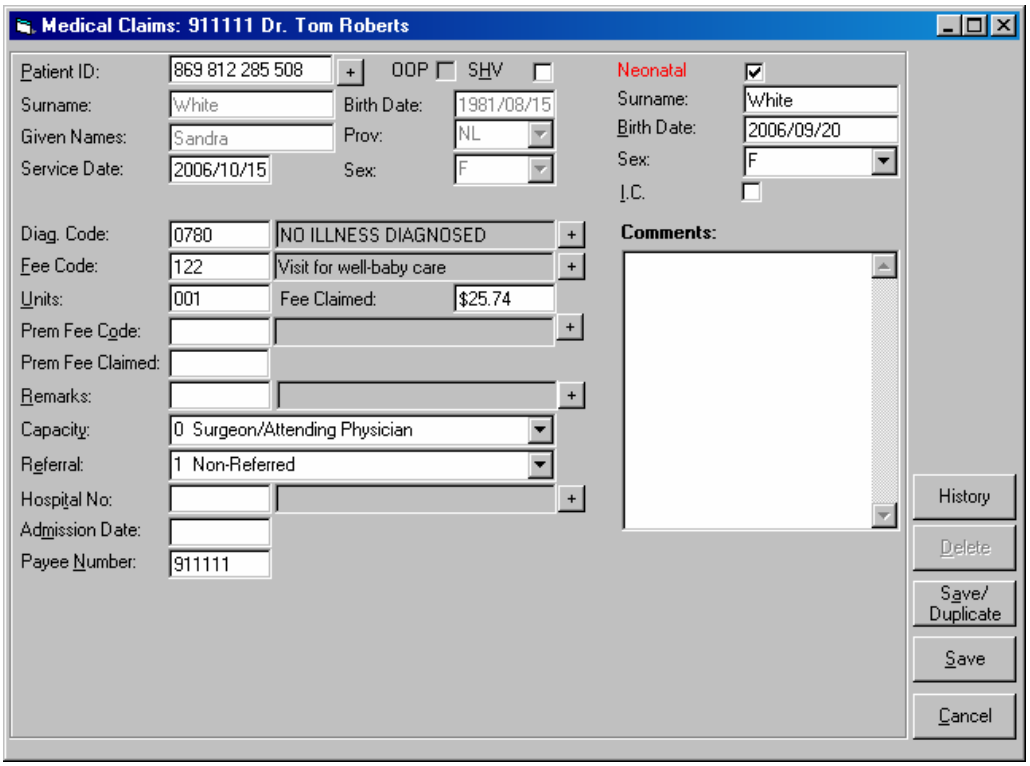


8.2.3 Case 3—Unregistered Sick Newborns

MCP has implemented arrangements whereby claims for insured services to unregistered sick newborns in the first 35 days of life may be submitted as soon as the service is rendered. For newborns who have not yet been registered and received MCP identity cards, claims may be submitted without MCP identity numbers provided the necessary information is submitted along with the claim. Please ensure the "neonatal" field is checked as well as providing the following information:

- mother's name, address, MCP number and telephone number
- infant's surname, first name if available, sex and exact date of birth

Case 3—Screen 1



Claims for services **after the first 35 days of life** must contain the infant's MCP number. Claims submitted without the MCP number after that period will be returned to the physician.

In cases where the infant has been registered and the MCP card is presented, the infant's MCP number should be entered on the claim which may then be submitted in the normal manner.

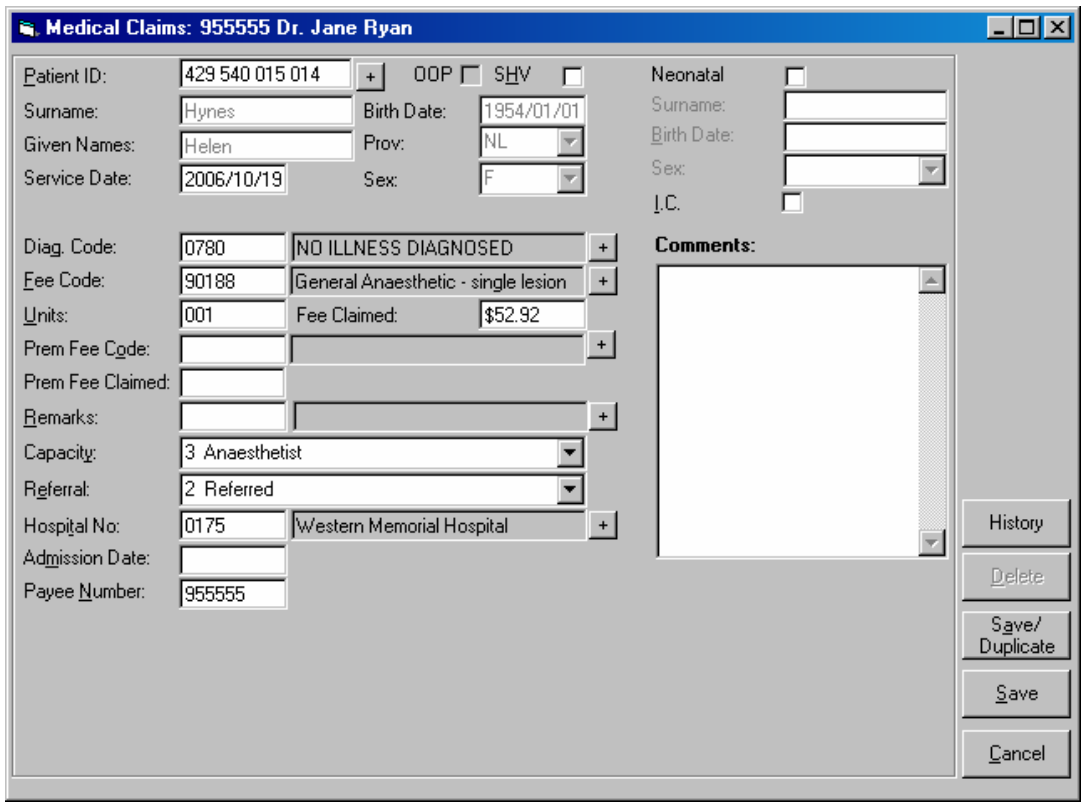
8.2.4 Case 4—Anaesthetic Services

Dr. Jane Ryan, an anaesthetist, provides a general anaesthetic for removal of a cyst.

Step 1—Basic

Physician bills fee code 90188—General Anaesthetic, Single Lesion at a basic rate of $52.92.

Case 4—Screen 1

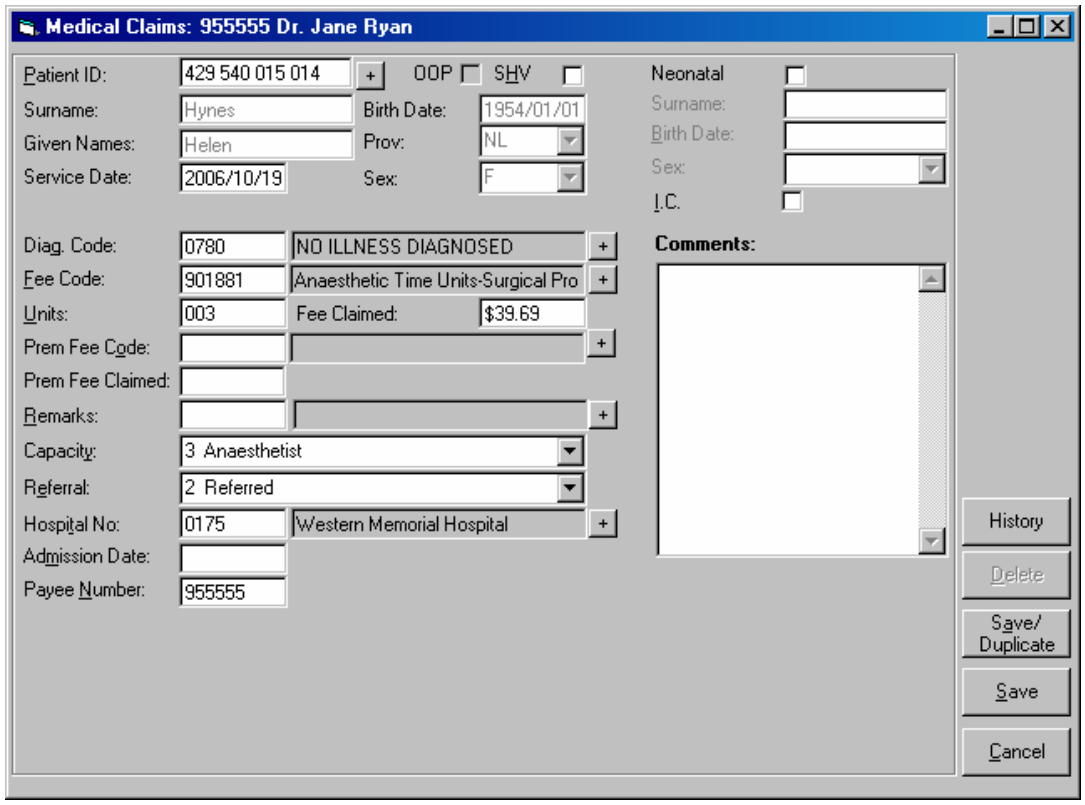


8.2.4 Case 4—Anaesthetic Services

Step 2—Time Units

Time units are defined as 15 minutes or part thereof. As the procedure took 45 minutes, Dr. Ryan has claimed 3 time units (refer to Payment Schedule, Table III—Anaesthetic Time Units—Surgical Procedures for basic fee equal to 4 or 5 time units). The appropriate fee code is the code for the procedure performed plus 1 in the last block of the fee code section. Therefore 901881 has been entered—$39.69.

Case 4—Screen 2



8.2.5 Case 5—Office Surgical Procedure

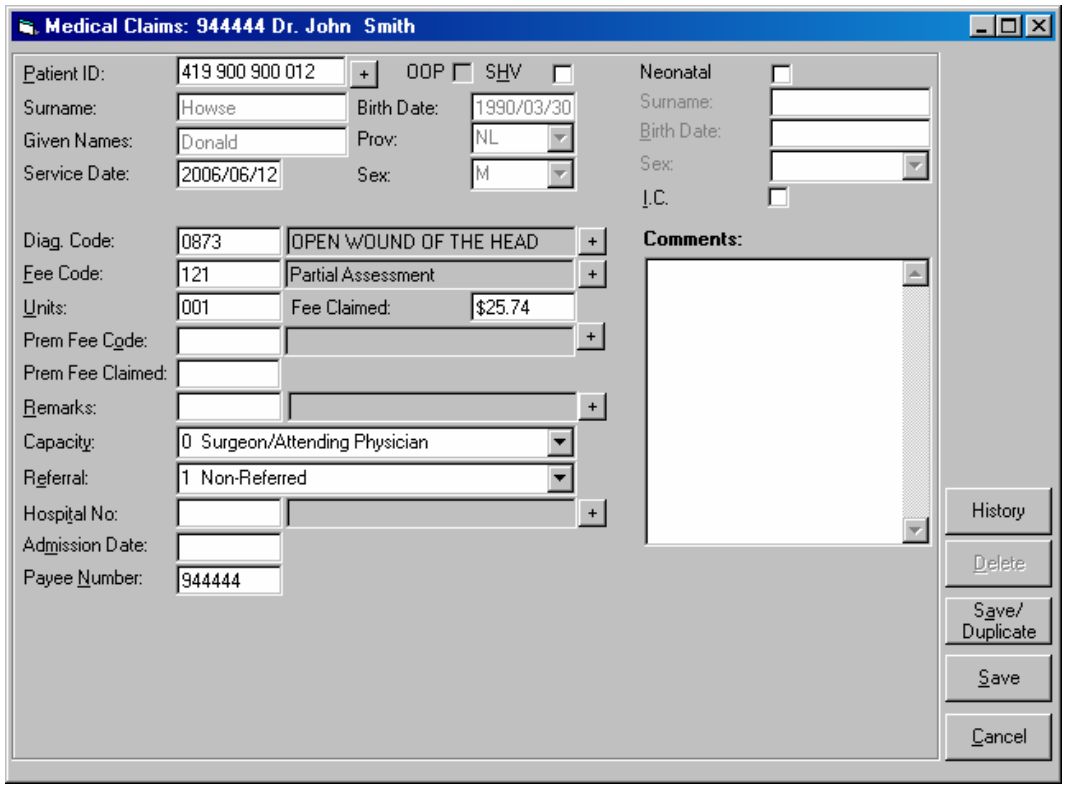
A patient visits Dr. Smith's office with a small laceration (less than 5 cm) on the side of his face. Dr. Smith sutures the laceration in the office and bills for the Partial Assessment as well as the Surgical Procedure. This includes:

Screen (1) Fee Code 121—Partial Assessment

Screen (2) Procedural Code 90312—Suture of Laceration up to 5 cm if on face and/or requires tying of bleeders and/or closure in layers

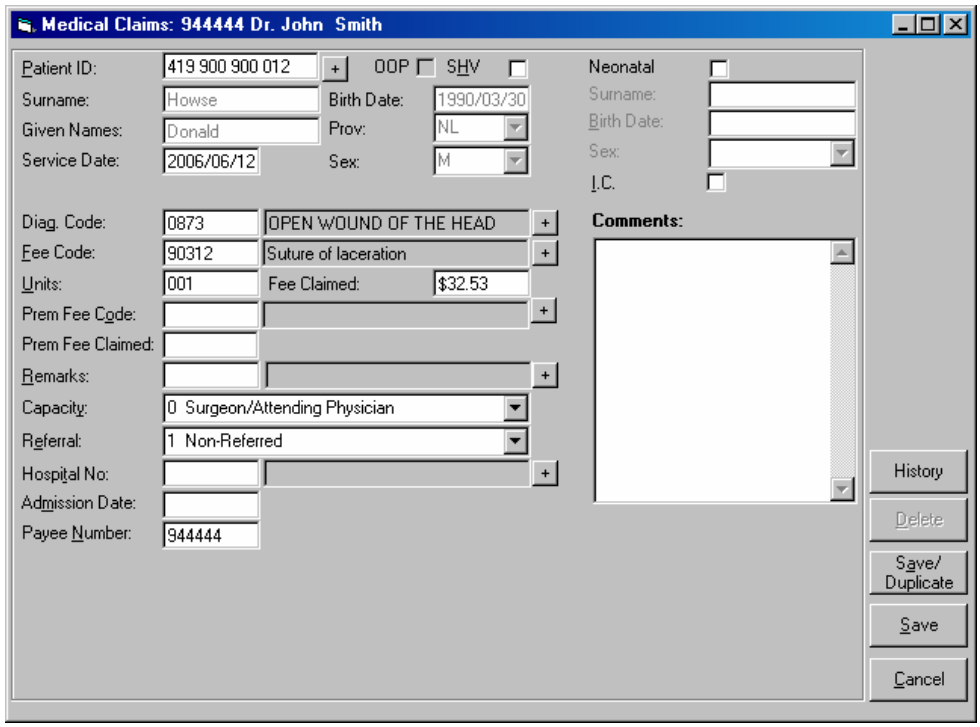
Screen (3) Procedural Code 90326—Suture of Laceration when rendered in private office or home

Case 5—Screen 1

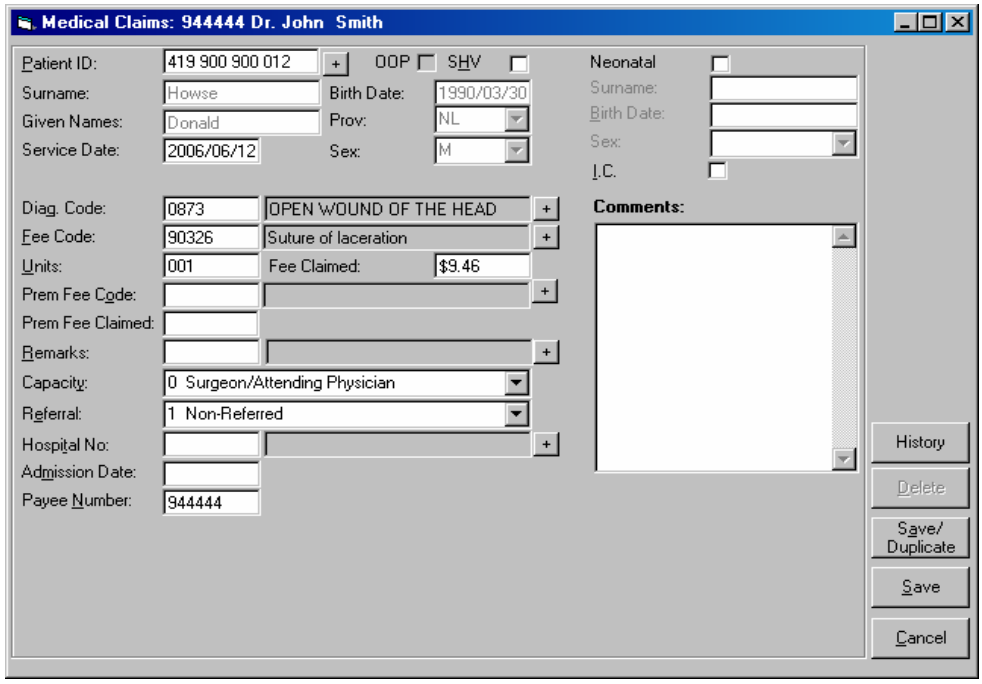


8.2.5 Case 5—Office Surgical Procedure

Case 5—Screen 2



Case 5—Screen 3



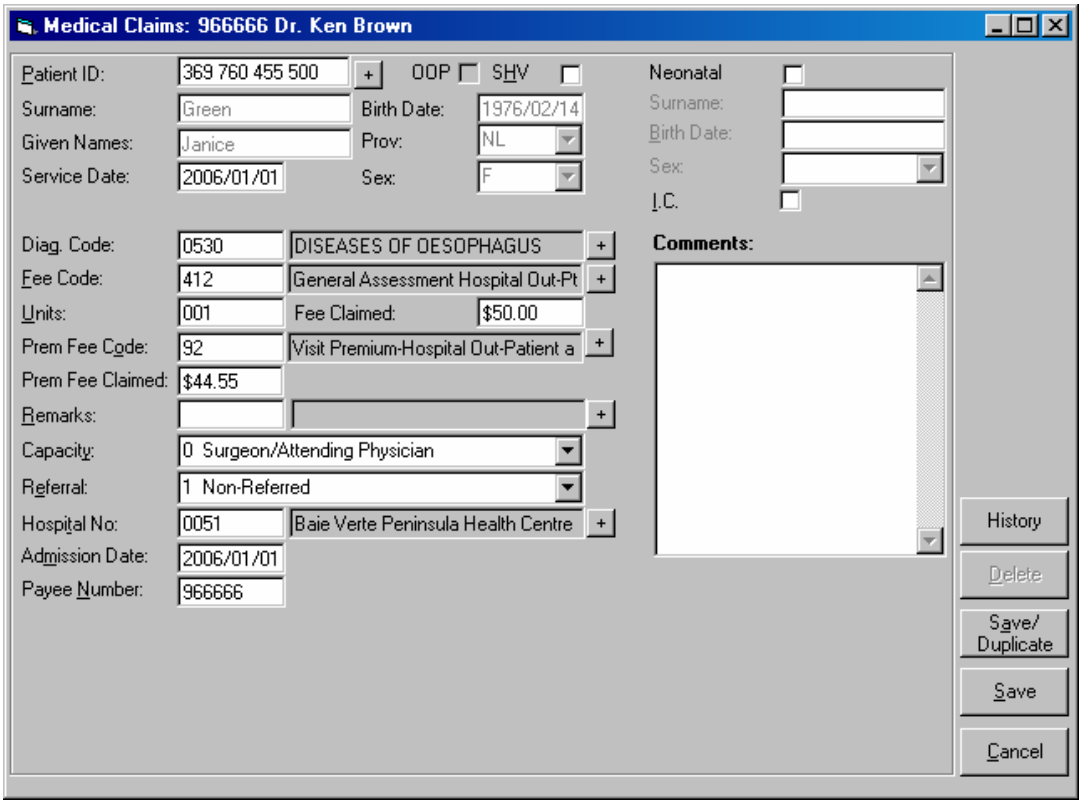
8.2.6 Case 6—General Assessment, Premium and SHV's

A female patient presents at the Baie Verte Peninsula Health Centre's emergency department on January 1, 2007 at 2200 hours. Her condition is such that her family physician, Dr. Brown, is called in to provide a General Assessment in the Out-Patient Department. She is then admitted to hospital until January 13, 2006.

Step 1

- Fee Code 412—General Assessment, Hospital Out-Patient and Emergency
- Visit Premium Fee Code 92—after hours premiums on out-patient services
- Hospital number—because the services are hospital based, the hospital number has been entered on the claim.

Case 6—Screen 1

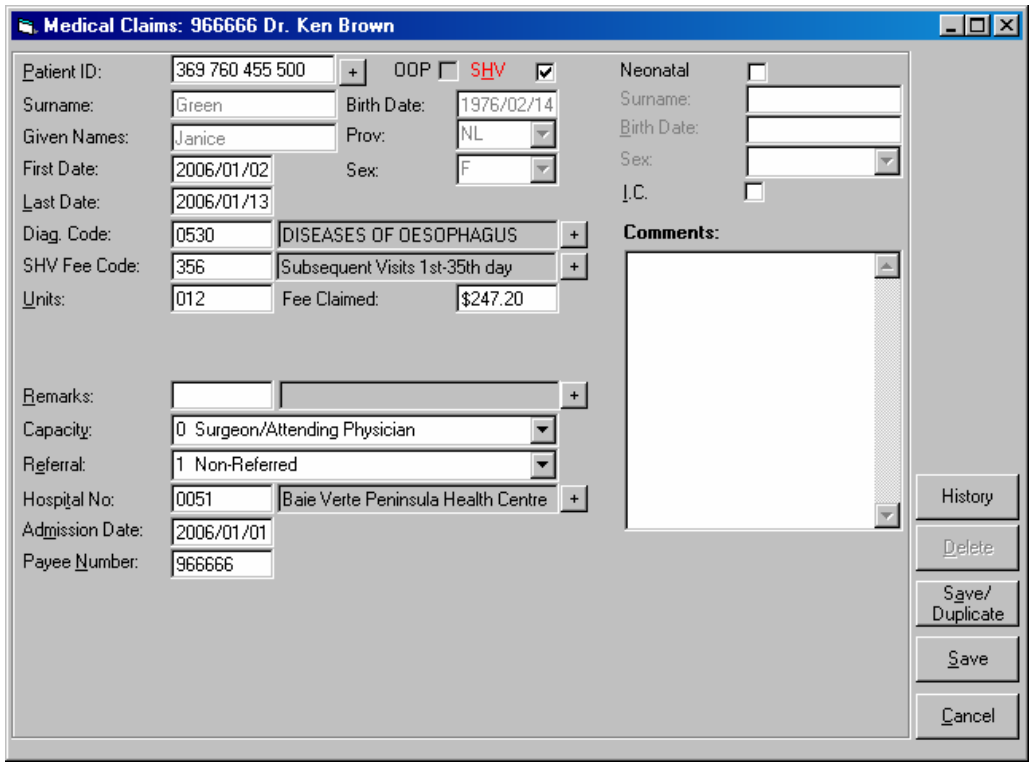


8.2.6 Case 6—General Assessment, Premium, and SHV's

Step 2

- Subsequent Hospital Visits (SHV's)—January 2-13, 2006. Dr. Brown claimed for a total of 12 SHV's at $20.60 per visit for a total of $247.20. The SHV field must be checked on the screen.
- As required, the hospital admission date was included on claim.

Case 6—Screen 2

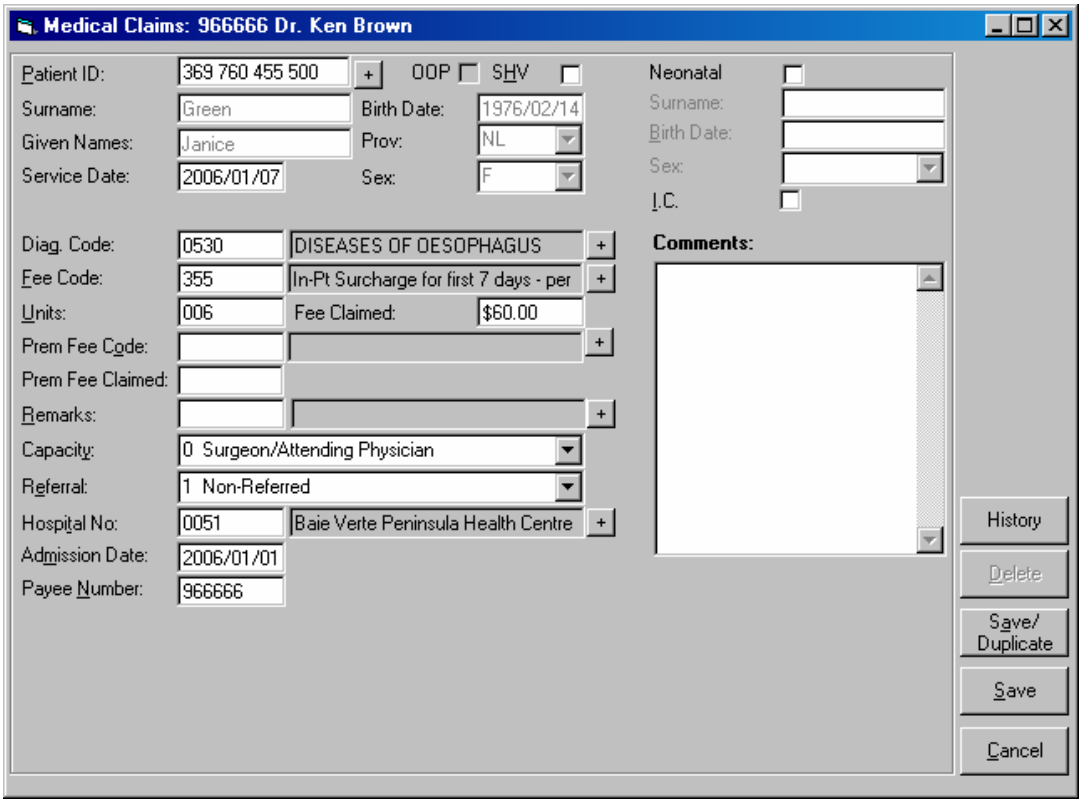


8.2.6 Case 6—General Assessment, Premium and SHV's

Step 3

- Dr. Brown is also eligible for claim an in-patient surcharge for first 7 days—per diem at $10 per day. In this case, patient was seen on the first day as an out-patient in emergency and is, therefore, not eligible for in-patient surcharge for this day. Physician is eligible to claim the next six days (January 2-7, 2006). Service date on claim must be entered as the last date payable, January 7, 2006.

Case 6—Screen 3

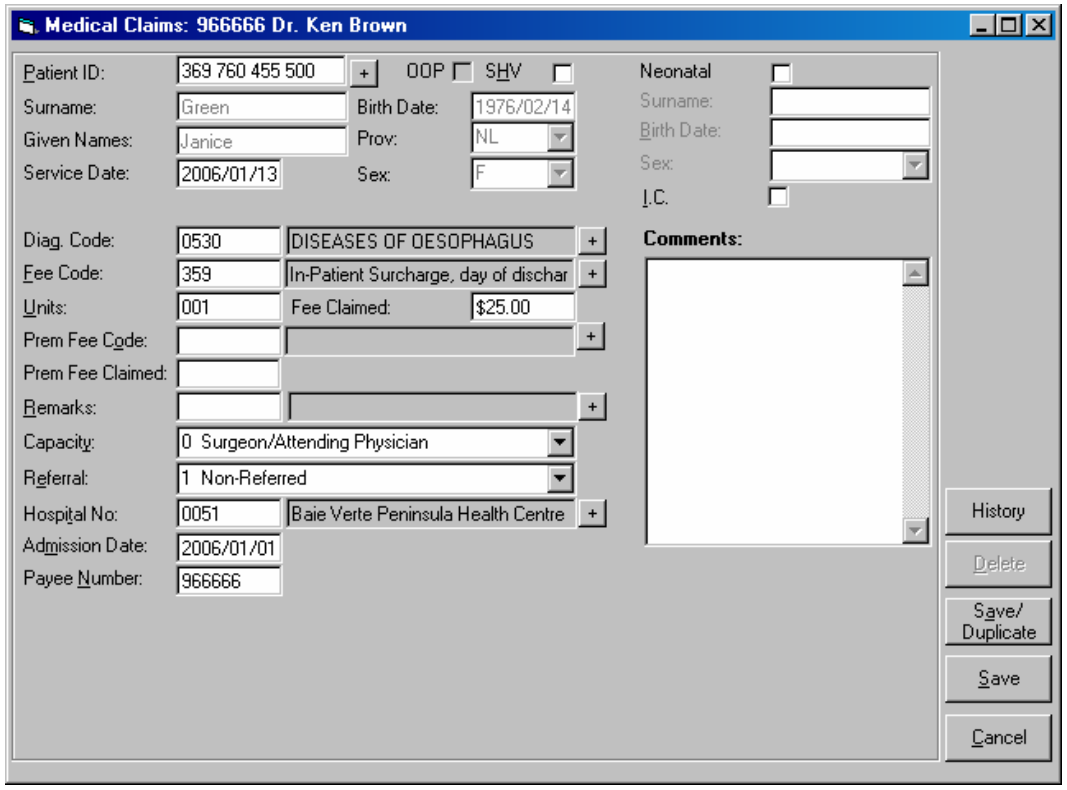


8.2.6 Case 6—General Assessment, Premium and SHV's

Step 4

- Dr. Brown also claims for in-patient surcharge, day of discharge—fee code 359 at a rate of $25.

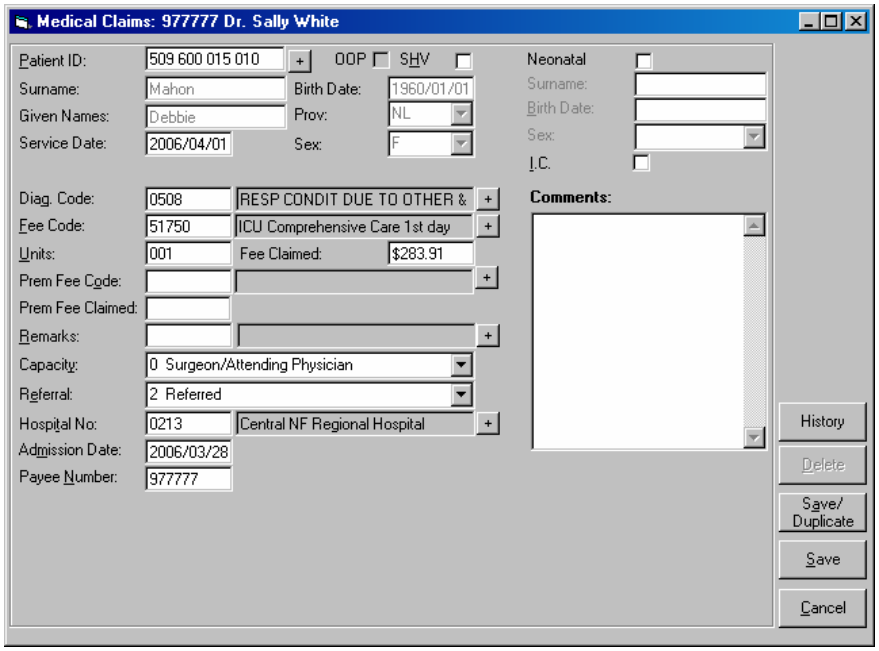
Case 6—Screen 4



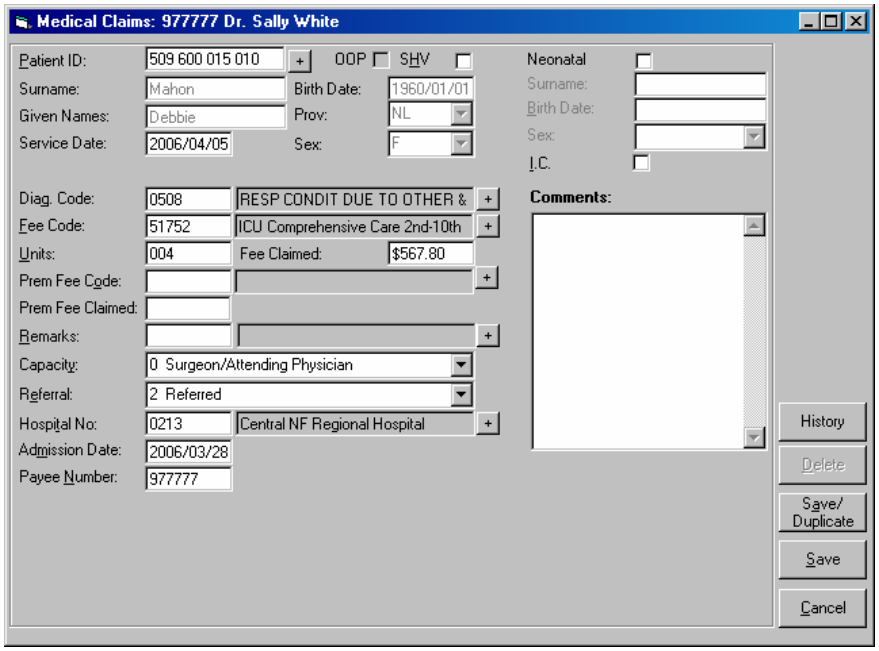
8.2.7 Case 7—ICU Services Provided by Specialist

A specialist, Dr. White, has provided ICU care to a patient from April 1-5, 2006. The patient was admitted to hospital on March 28, 2006.

Screen (1) First day ICU. Comprehensive Care on April 1, 2006 using Fee Code 51750.



Screen (2) Second to the tenth day ICU Comprehensive Care from April 2-5 (four days), using April 5th as the service date, billing fee code 51752.



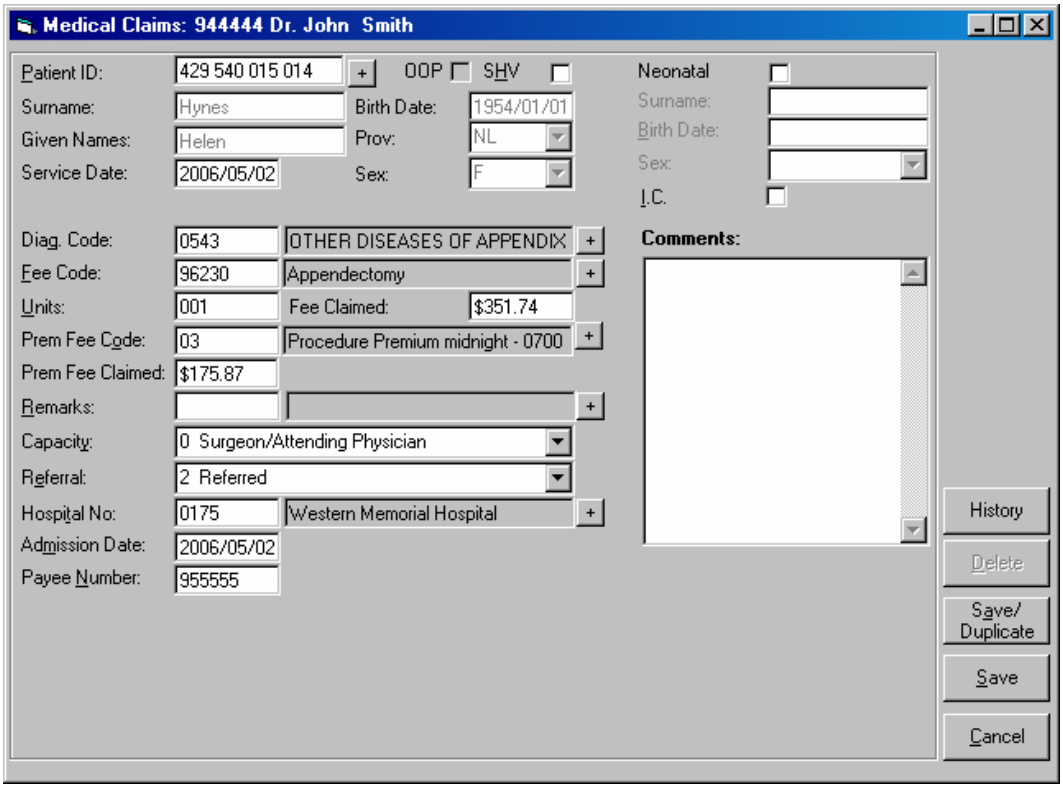
8.2.8 Case 8(A)—Unscheduled Surgical Procedure

Dr. Smith has billed for an emergency appendectomy performed between midnight and 0700 hours. The patient was admitted on May 2, 2006.

Fee codes used and fees claimed by Dr. Smith:

- Fee code 96230—Appendectomy at $351.74.
- Premium fee code 03 for the premium on the surgical procedure which was performed between midnight and 0700 hours—50% of procedure fee ($351.74) = $175.87.
- Dr. Smith is completing a locum for Dr. Ryan. For billing purposes, Dr. Smith has assigned payment of this claim to Dr. Ryan. In order to have this done, both doctors have signed an Assignment of Payment Agreement. Dr. Ryan's payee number is 955555.

Case 8(A)—Screen 1



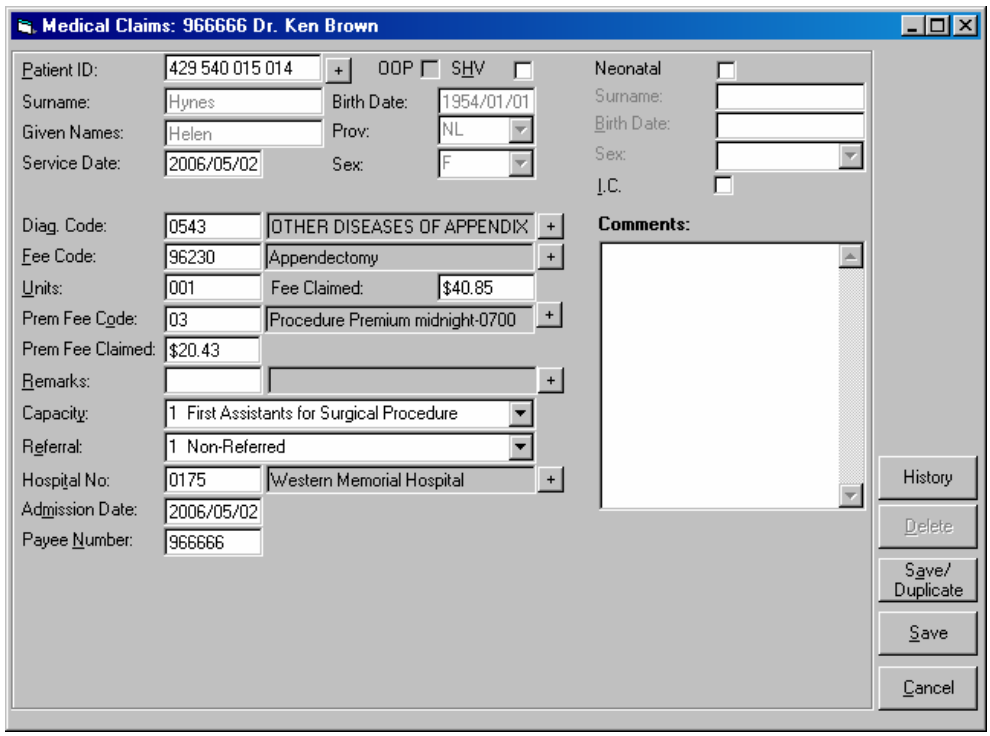
8.2.8 Case 8(B)—Unscheduled Surgical Assistant Services

Dr. Brown has provided surgical assistant services for an emergency appendectomy procedure between midnight and 0700 hours.

Step 1

- Because Dr. Brown is the surgical assistant to Dr. Smith, he has entered a capacity code of 1.
- Basic assistant's fee code for the surgical procedure is 96230 at a rate of $40.85.
- Premium fee code 03 as the procedure was performed between midnight and 0700 hours—50% of the fee ($40.85) = $20.43.

Case 8(B)—Screen 1

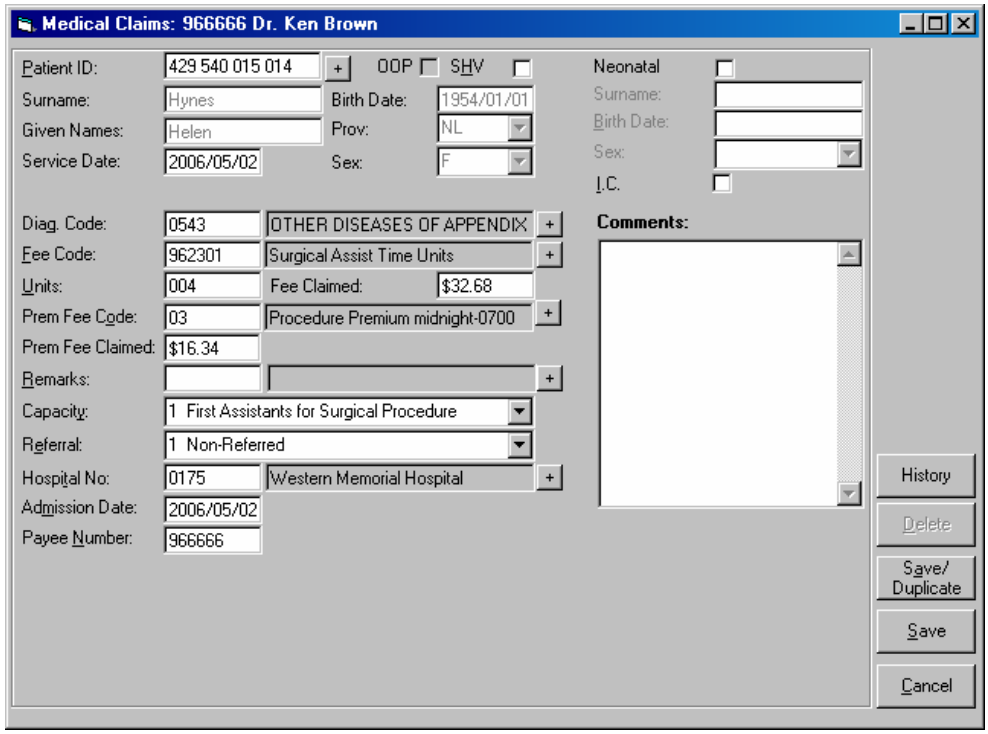


8.2.8 Case 8(B)—Unscheduled Surgical Assistant Services (cont'd)

Step 2

- As the procedure took one hour, the assistant has properly claimed four time units at $8.17 per unit (refer to Table VI—Units Table for Surgical Assistants Billing According to Standard Time Method). A time unit is defined as 15 minutes or part thereof. The appropriate fee code is the code for the procedure performed plus the digit 1 in the sixth block. Therefore, 962301 has been entered as $32.68.
- The premium fee is calculated as a percentage of the time units. Premium fee code 03 is used as the procedure started within the time frame of midnight to 0700. This premium fee is 50% of the fee claimed for the time units ($32.68) = $16.34.

Case 8(B)—Screen 2



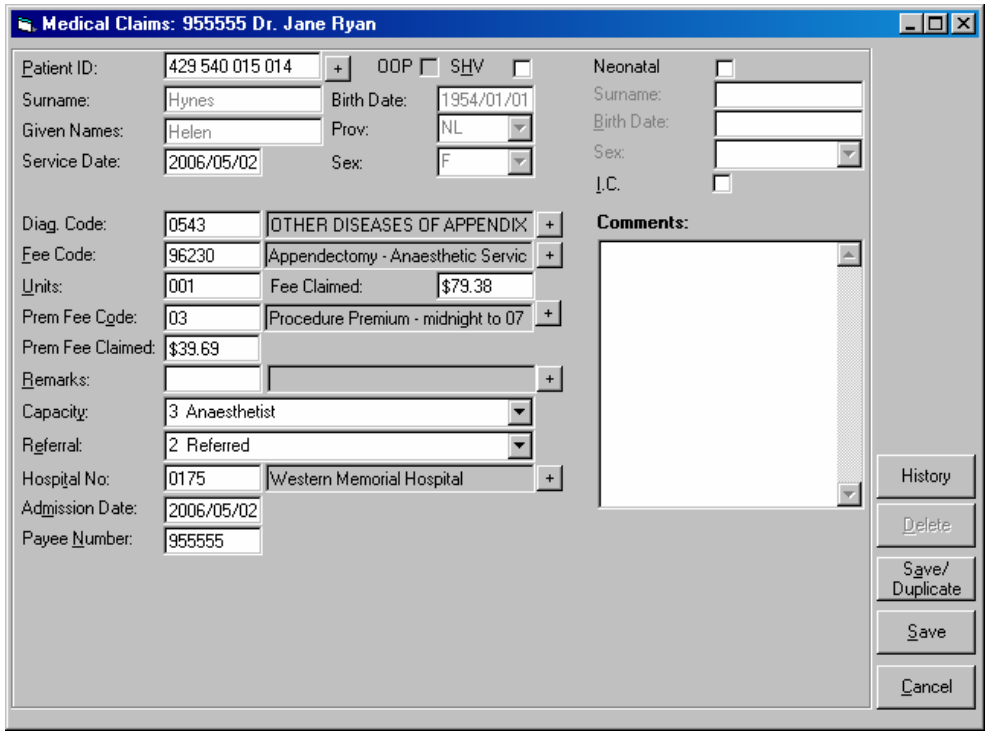
8.2.8 Case 8(C)—Unscheduled Anaesthetic Services

Dr. Ryan, an Anaesthetist, provides one hour service (midnight to 0700) to a patient during the appendectomy performed by Dr. Smith and Dr. Brown.

Step 1

- Dr. Ryan bills fee code 96230 at $79.38 (Refer to Payment Schedule, find fee code 96230, Spec. Anaes. column indicates a unit value of 6. Refer to Table 1—Anaesthesia Basic Fee Code Rates, a basic unit of 6 indicates a rate of $79.38.)
- Dr. Ryan is also eligible to claim an after hours surgical procedure premium code 03 which is 50% of the fee code billed (96230) = $39.69.

Case 8(C)—Screen 1

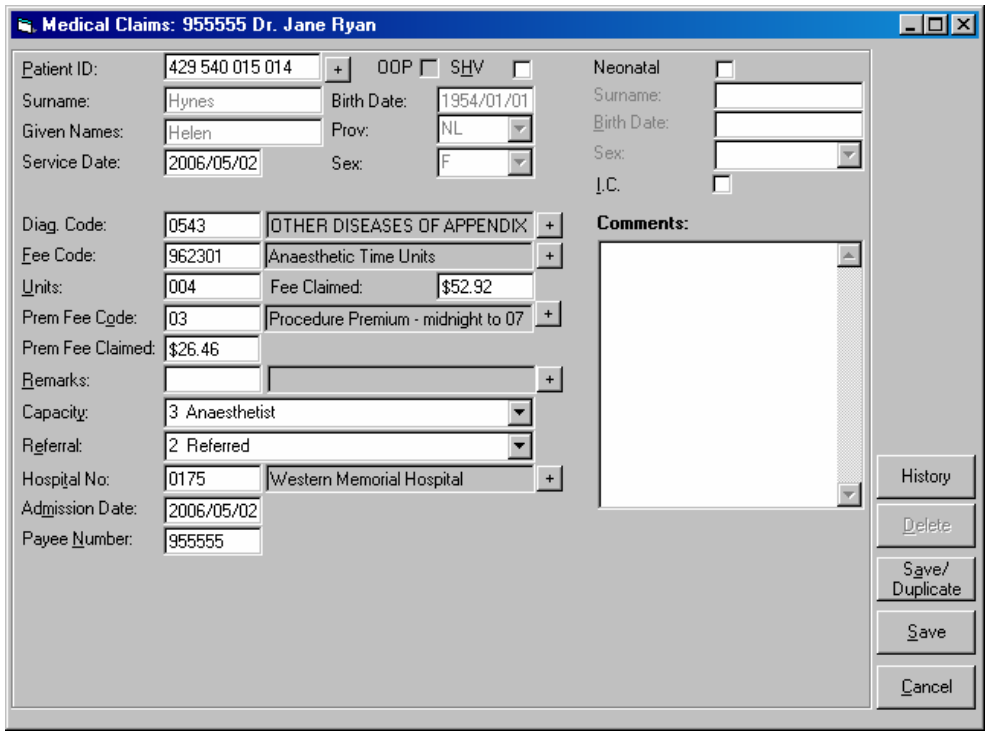


8.2.8 Case 8(C)—Unscheduled Anaesthetic Service (cont'd)

Step 2

- Time units are defined as 15 minutes or part thereof. As the procedure took 60 minutes Dr. Ryan has claimed 4 time units (refer to Payment Schedule, Table II—Anaesthetic Time Units – Surgical Procedures for basic fee equal to 1-3 time units or 6 or more time units). The appropriate fee code is the code for the procedure performed plus 1 in the last block of the fee code section. Therefore 962301 has been entered with a rate of $52.92.
- An after hours surgical procedure premium code 03 has been billed, which is 50% of the fee code billed (962301) = $26.46.

Case 8(C)—Screen 2



8.2.9 Case 9(A)—Hospital In-Patient Surgical Procedures

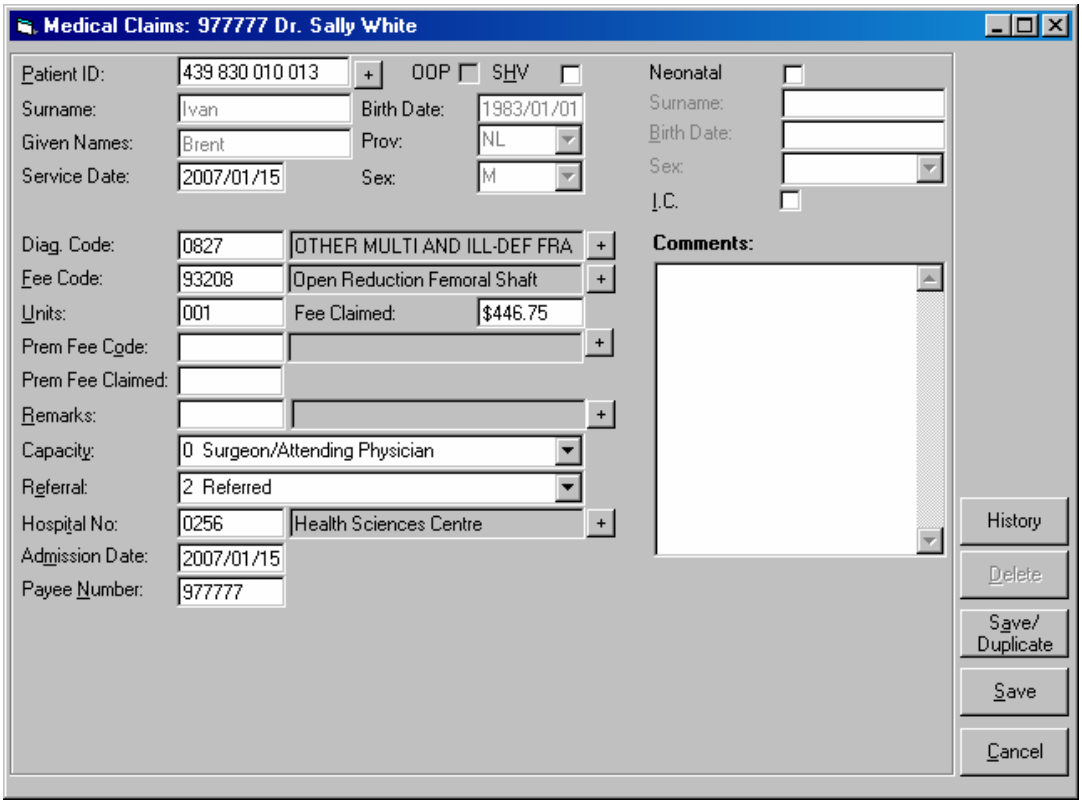
Dr. White, an orthopaedic surgeon, has billed for more than one operative procedure under the same anaesthetic—an open reduction femoral shaft/supracondylar and tibia with or without fibula open reduction-shaft. The patient was admitted on January 15, 2007.

When more than one operative procedure is performed by the same surgeon at the same time under the same anaesthetic, the fee shall be the full fee for the major procedure and all other procedures shall be paid at the rate of 85% of the listed fee for each procedure.

Step 1

- Fee code 93208—femoral shaft/supracondylar open reduction at $446.75.

Case 9(A)—Screen 1

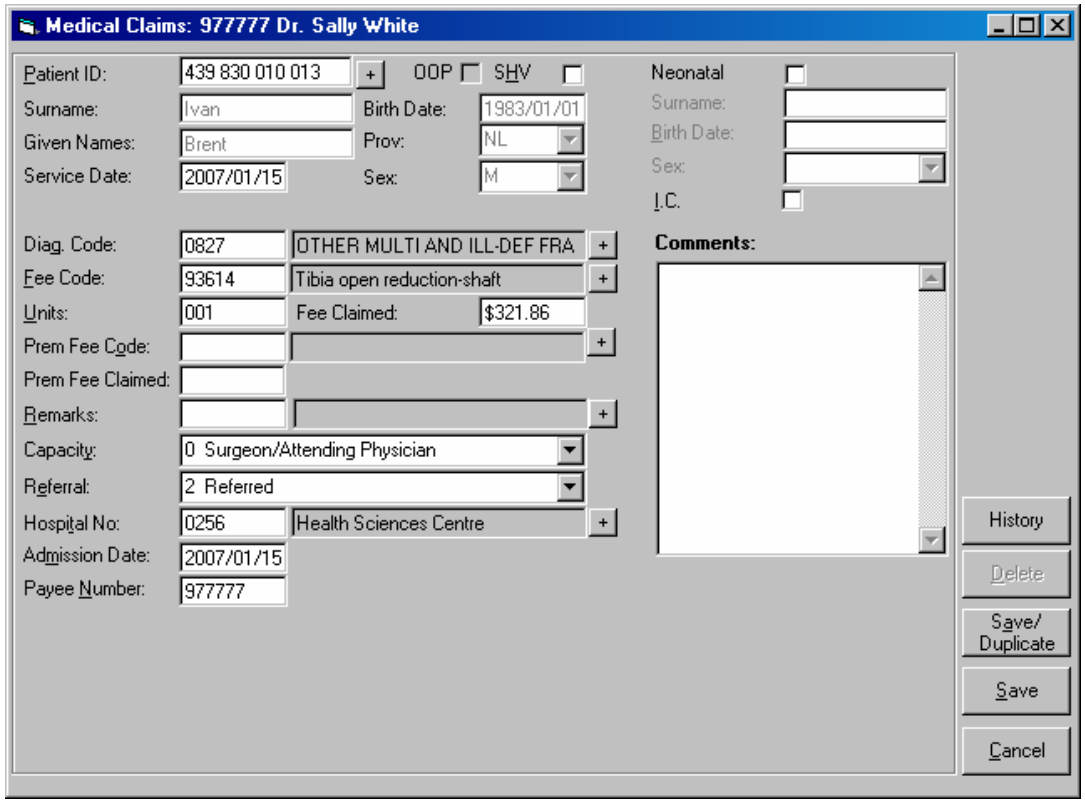


8.2.9 Case 9(A)—Hospital In-Patient Surgical Procedures (cont'd)

Step 2

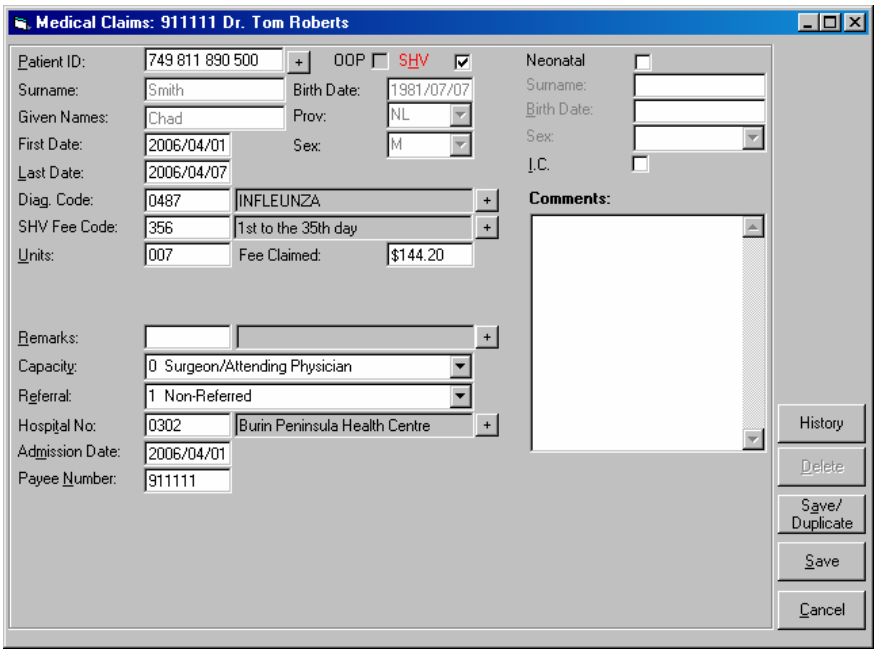
- Fee Code 93614—Tibia with or without fibula, open reduction-shaft, 85% of the listed fee ($378.66) = $321.86.

Case 9(A)—Screen 2

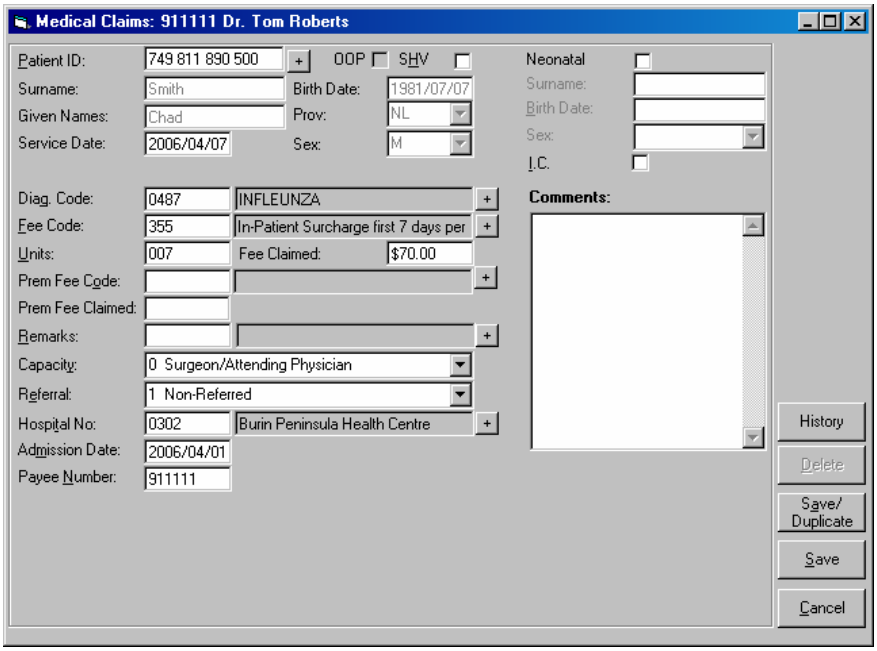


8.2.10 Case 10—Consultations & Visits—Hospital In-Patient

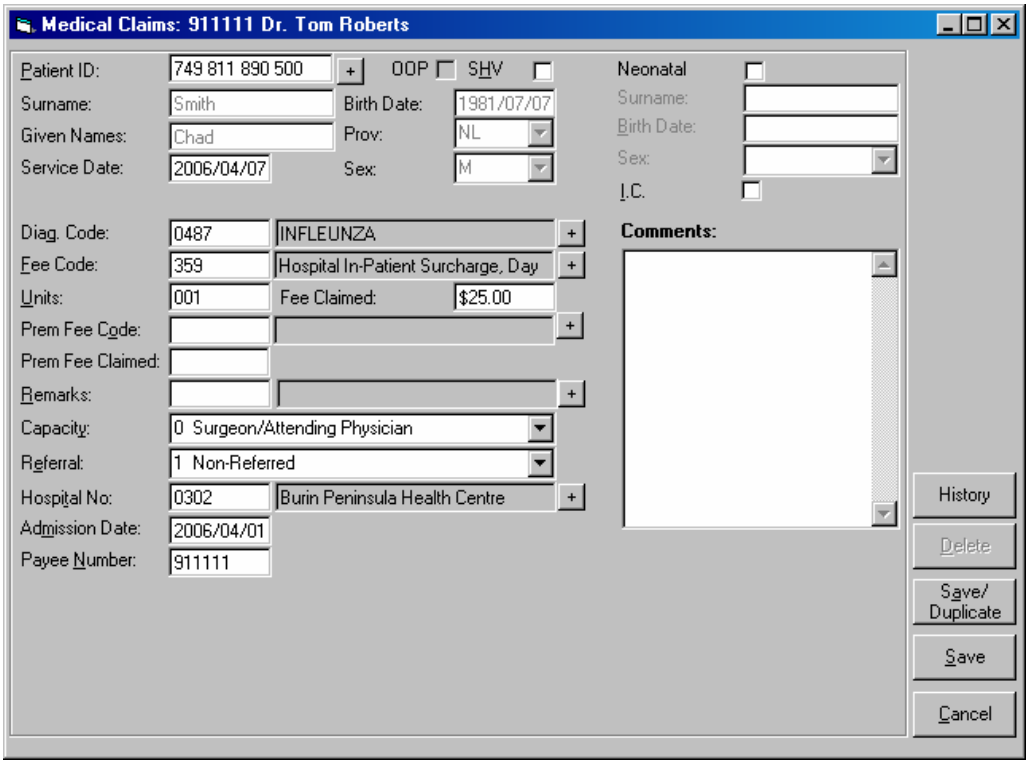
Screen (1) Patient is admitted to hospital from April 1-7, 2006 under Dr. Robert's care. Dr. Roberts is eligible to bill hospital in-patient subsequent hospital visits (SHV's) at a rate of $20.60 per day for April 1-7. Ensure the SHV field is checked on the screen.



Screen (2) Dr. Roberts is also eligible to bill fee code 355, in-patient surcharge for first seven days, at a rate of $10 per diem for the first seven days because the corresponding in-patient fee code has been paid. Enter last date payable as service date, April 7, 2006.



Screen (3) Dr. Roberts also claims for in-patient surcharge, day of discharge—fee code 359 at a rate of $25.00 for April 7, 2006.



8.3 INDEPENDENT CONSIDERATION (IC) CLAIMS

Specific services are designated as billable on an "IC" basis only. Physicians are required to identify claims for these services as IC and to provide additional applicable information, according to instructions in the Payment Schedule or in this manual.

Services not listed in the Payment Schedule, or for which a set fee is not listed, must be billed IC. For these services an IC claim must include:

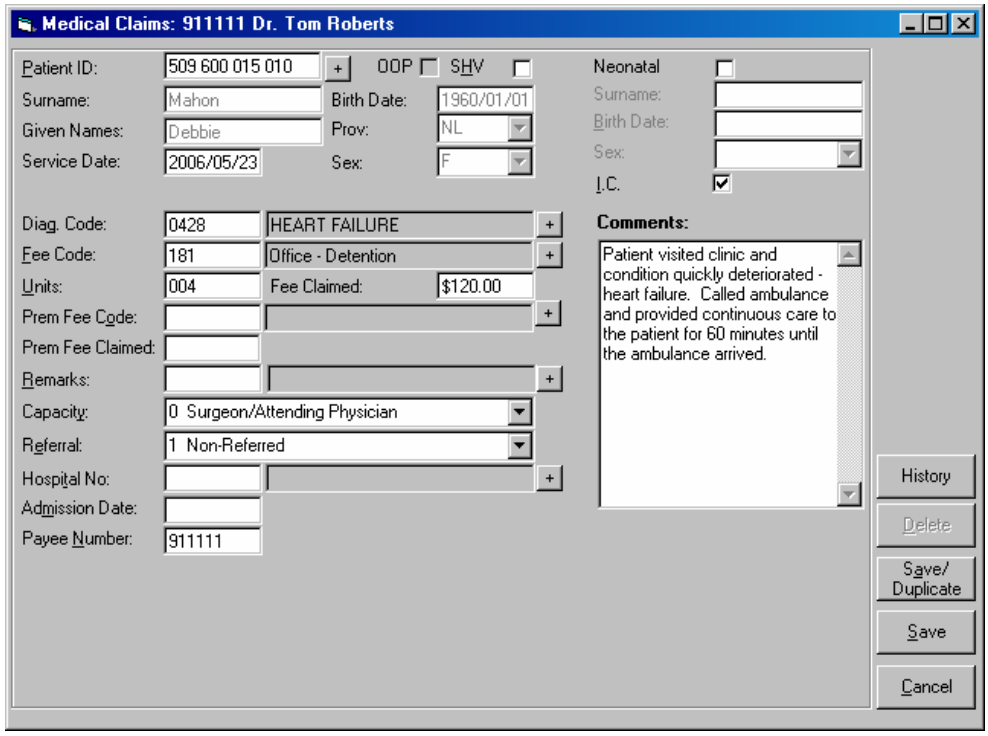
- the time involved in direct continual attendance with the patient or in performing the procedure claimed, whichever applies
- a list of all examinations and procedures performed which are represented by the claim
- the actual size of lesions removed or laceration repaired, or the area of any defect which was repaired, if applicable
- comparison in scope and difficulty of the procedure with other procedures listed in the Payment Schedule and
- a copy of the operative report along with the actual operating time for complex surgical procedures.

Examples of properly completed IC fields are shown on the pages which follow. Following these examples is a listing of the fee codes in the Payment Schedule that must be marked IC, as well as the types of information required.

8.3.1 Case Sample of IC—Detention

Dr. Roberts, a General Practitioner, is in private practice. On May 23, 2006 he completes a Partial Assessment on a patient who complains of chest pains. During the examination, the patient's condition quickly deteriorates—heart failure. Dr. Roberts calls an ambulance and remains with the patient continuously until the ambulance arrives. Dr. Roberts provides 60 minutes of continuous care to this patient.

Dr. Roberts submits a normal claim for the Partial Assessment. As per the General Preamble, he may also bill 60 minutes "Detention". Claims for Detention must be billed IC and include information as to the nature of the patient's condition, actual time spent in continuous attendance and a brief description of the service(s) rendered.

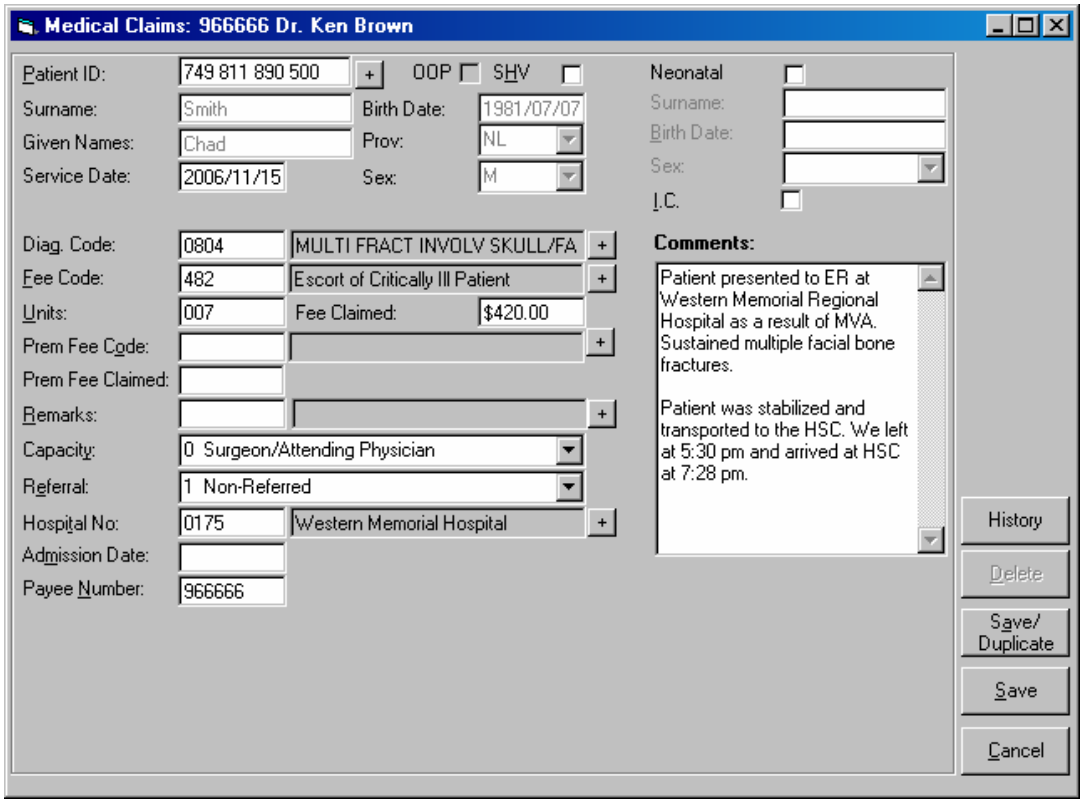


8.3.2 Case Sample of IC—Escort of a Critically Ill Patient

Dr. Brown is a General Practitioner at the Emergency Room at Western Memorial Hospital in Corner Brook.

Patient presented to the regional hospital emergency room as a result of a motor vehicle accident. Patient sustained multiple facial bone fractures; patient was then stabilized and transported to the Health Science Centre for definitive treatment.

Dr. Brown bills for the Partial Assessment and then bills for the escort of a critically ill patient. As per the General Preamble, this service must be billed IC. The information should include the actual start and finish time and the critical nature of the illness requiring physician's presence.



8.3.3 Requirements for Billing of Certain Fee Codes Indicated as IC

FEE CODE	IC INFORMATION REQUIRED
181	When billing for either of these detention codes, the IC must include information as to the nature of the patient's condition requiring the physician's presence, the actual time spent in continuous attendance to the exclusion of all other duties, and a brief description of the services rendered.
281	When billing for either of these detention codes, the IC must include information as to the nature of the patient's condition requiring the physician's presence, the actual time spent in continuous attendance to the exclusion of all other duties, and a brief description of the services rendered.
381	When billing for either of these detention codes, the IC must include information as to the nature of the patient's condition requiring the physician's presence, the actual time spent in continuous attendance to the exclusion of all other duties, and a brief description of the services rendered.
481	When billing for either of these detention codes, the IC must include information as to the nature of the patient's condition requiring the physician's presence, the actual time spent in continuous attendance to the exclusion of all other duties, and a brief description of the services rendered.
482	Indicate the following: (a) the actual start and finish time for the in-transit period (finish time is defined by the time the patient is transferred to the care of a physician willing to accept responsibility for the patient). (b) the critical nature of the illness requiring physician presence.
54160	Indicate the applicable nerve block fee code and specify that it is for post-op pain.
54254	Indicate the number of transfusions.
54256	Indicate the need for the assistance of a physician.
54270	Indicate the medical necessity for the procedure.
54850	Indicate the condition for which the procedure was done.
54852	Indicate the condition for which the procedure was done.
54854	Indicate the condition for which the procedure was done.
71509	Indicate IC on the claim and note that a copy of the report is being forwarded. Submit a copy of the report.
71535	Indicate IC on the claim and note that a copy of the report is being forwarded. Submit a copy of the report.
71539	Indicate IC on the claim and note that a copy of the report is being forwarded. Submit a copy of the report.

FEE CODE	IC INFORMATION REQUIRED
71619	Indicate IC on the claim and note that a copy of the report is being forwarded. Submit a copy of the report.
71719	Indicate IC on the claim and note that a copy of the report is being forwarded. Submit a copy of the report.
71731	Indicate IC on the claim and note that a copy of the report is being forwarded. Submit a copy of the report.
71985	Indicate the name of the procedure, the physician who performed the procedure and the amount of time involved.
72050	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72101	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72105	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72111	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72113	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72115	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72117	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72119	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72131	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72141	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72151	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72201	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72221	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72223	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72225	Indicate why the procedure had to be completed by the Radiologist rather than the technician.

FEE CODE	IC INFORMATION REQUIRED
72227	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72229	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72231	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72233	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72341	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72361	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72401	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72404	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72451	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72501	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72511	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72521	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72531	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72541	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72551	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72561	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72571	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72611	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
72621	Indicate why the procedure had to be completed by the Radiologist rather than the technician.
73853	Indicate the fee code on which to base the 30%.

FEE CODE	IC INFORMATION REQUIRED
73863	Indicate the fee code on which to base the 30%.
73868	Indicate the fee code on which to base the 30%.
73895	Indicate the fee code on which to base the 30%.
80044	When pre-delivery plus delivery and/or post-delivery time units are greater than 12, clarify the times in each phase.
80046	Indicate the reason the anaesthetist was asked to attend.
90020	Indicate why it was necessary for the physician to stand by.
90130	Clarify why the procedure was complicated and identify the site, size, and foreign body.
90140	Indicate what the exceptional basis was and the number of biopsies, sites, and sizes.
90142	Indicate why the procedure was complicated, the number of biopsies done, sites, and sizes.
90168	Indicate the site, the measurement, and the reason for the removal.
90194	Indicate the actual size and the site.
90208	Indicate the site and size.
90228	Indicate the size and site, or why the procedure was complex.
90270	Indicate the nature of the lesions, the site(s), size(s), and the number.
90308	Indicate site, size, and the nature of the wound.
90322	Indicate the site and size.
90332	Indicate the muscle repaired and why the procedure was complex.
90348	Indicate the medical necessity for the procedure, site, and size.
90378	Indicate the site, size, and nature of the defect.
90394	Indicate the site, size, and nature of the defect.
90432	Indicate the type of flap, site and size.
90454	Indicate the nature of the defect, site and size.
90460	Indicate IC on the claim and in the comments note that a copy of the procedural report is being forwarded. Indicate the site and size if not indicated in the report. Submit the report.
90462	Indicate IC on the claim and in the comments note that a copy of the procedural report is being forwarded. Indicate the site and the size if not indicated in the report. Submit the report.
90532	Indicate the type of flap revised and give a description of the procedure.

FEE CODE	IC INFORMATION REQUIRED
90534	Indicate the type of flap, site, size, and nature of the defect, and give a description of the procedure.
90660	Indicate the percentage of the scalp grafted and note any complicating factors.
90666	Indicate the percentage of the neck grafted and note any complicating factors.
90670	Indicate the medical necessity for the procedure and give a description of the procedure performed. A copy of the procedural report will be accepted in lieu of the description (if a copy of the report is submitted, indicate IC on the claim and note in the comments that a copy of the report is being forwarded).
90672	Indicate the medical necessity for the procedure and give a description of the procedure performed. A copy of the procedural report will be accepted in lieu of the description (if a copy of the report is submitted, indicate IC on the claim and note in the comments that a copy of the report is being forwarded).
90674	Indicate the medical necessity for the procedure and give a description of the procedure performed. A copy of the procedural report will be accepted in lieu of the description (if a copy of the report is submitted, indicate IC on the claim and note in the comments that a copy of the report is being forwarded).
90676	Indicate the medical necessity for the procedure and give a description of the procedure performed. A copy of the procedural report will be accepted in lieu of the description (if a copy of the report is submitted, indicate IC on the claim and note in the comments that a copy of the report is being forwarded).
90678	Indicate the medical necessity for the procedure and give a description of the procedure performed. A copy of the procedural report will be accepted in lieu of the description (if a copy of the report is submitted, indicate IC on the claim and note in the comments that a copy of the report is being forwarded).
90808	Indicate the fee code for the excision on which the fee is based.
91120	Indicate the size, site, and the description of the procedure.
91254	Give a description of the procedure.
91258	Give a description of the procedure.
91998	Indicate IC on the claim and note in the comments that a copy of the procedural report is being forwarded. Submit a copy of the report.
92000	Indicate IC on the claim and note in the comments that a copy of the procedural report is being forwarded. Submit a copy of the report.
92004	Indicate IC on the claim and note in the comments that a copy of the procedural report is being forwarded. Submit a copy of the report.
92006	Indicate IC on the claim and note in the comments that a copy of the procedural report is being forwarded. Submit a copy of the report.
92070	Indicate the site, size, and description of the procedure.
92436	Indicate why the procedure was complicated.

FEE CODE	IC INFORMATION REQUIRED
94480	Indicate IC on the claim and note in the comments that a copy of the procedure report is being forwarded. Submit a copy of the report.
94600	Indicate IC on the claim and note in the comments that a copy of the procedure report is being forwarded. Submit a copy of the report.
94602	Indicate IC on the claim and note in the comments that a copy of the procedure report is being forwarded. Submit a copy of the report.
94754	Give a description of the procedure, or submit a copy of the procedure report (indicate IC on the claim and note in the comments that a copy of the report is being forwarded).
94770	Give a description of the service or submit a copy of the procedure report (if you submit copy of the report, indicate IC on the claim and note in the comments that a copy of the report is being forwarded).
94780	Indicate IC on the claim and in the comments note that a copy of the procedure report is being forwarded. Submit a copy of the report.
94970	Indicate IC on the claim and in the comments note that a copy of the procedure report is being forwarded. Submit a copy of the report.
94972	Indicate IC on the claim and in the comments note that a copy of the procedure report is being forwarded. Submit a copy of the report.
94974	Indicate IC on the claim and in the comments note that a copy of the procedure report is being forwarded. Submit a copy of the report.
94976	Indicate IC on the claim and in the comments note that a copy of the procedure report is being forwarded. Submit a copy of the report.
95058	Indicate what artery was explored and any significant anaesthetic factors.
95304	Indicate what vein was involved and describe the procedure.
95360	Indicate IC on the claim and in the comments note that a copy of the procedure report is being forwarded. Submit a copy of the report.
95362	Indicate IC on the claim and in the comments note that a copy of the procedure report is being forwarded. Submit a copy of the report.
95514	Indicate the medical necessity for the procedure **and** give a description of the procedure, or, in lieu of the description, submit a copy of the procedural report. If you submit a copy of the report, indicate IC on the claim and note in the comments that a copy of the report is being forwarded.
95550	Indicate the size and the complexity involved.
96324	Give a description of the procedure or submit a copy of the procedure report (if you submit the report copy, indicate IC on the claim and in the comments note that the report copy is being forwarded).
96452	Indicate IC on the claim and note in the comments that a copy of the procedure report is being forwarded. Submit a copy of the report.
96454	Indicate IC on the claim and note in the comments that a copy of the procedure report is being forwarded. Submit a copy of the report.

FEE CODE	IC INFORMATION REQUIRED
96610	Indicate what the emergency was and what service was provided by the surgeon called in.
96690	Indicate IC on the claim and in the comments note that a copy of the procedure report is being forwarded. Submit a copy of the report.
97556	Indicate the size of the laceration and any complications.
97710	Indicate the size, depth, and any complication.
98834	Indicate the nature and number of the foreign bodies.

8.4 CODING SYSTEMS

The following coding systems are necessary for completion of claims—Remarks Codes, Diagnostic Codes, Hospital/Facility Codes.

8.4.1 Remarks Codes

The purpose of these codes is to indicate on the claim pertinent remarks regarding the claim being submitted. If a claim requires more than one Remark, the details should be entered in the "Comments" section and the claim flagged as an "IC" claim. Remarks Codes are listed on the following pages.

MEDICAL REMARKS CODES

CODE	CONDITION	REMARKS
01	Multiple (2 or more) units of either fee code 121 or 421 billed	The indicated number of separate visits billed as code 121 or 421 were made this day, and, each subsequent visit was **not** a continuation of care, etc. from the previous visit this day. To be paid as separate visits, multiple services provided to a patient may not be initiated by the physician or may not be a continuation of a service which began earlier in the day. An example of continuation of service is the time spent with a patient to review x-ray or laboratory results ordered during an examination of the patient earlier in the day. If the patient initiates the second and subsequent encounter(s) or the physician is requested to attend the patient by hospital staff, additional encounters may be claimed
02	Fee Code 97390 to 97396 billed	This dilation was done for relief of stricture, **not** for access purposes
03	Bilateral procedures done on same date	Bilateral procedure
04	Multiple separate visits on the same service date	The visits billed are separate visits and each subsequent one was not a continuation of care from the previous one by this physician or by another physician. To be paid as separate visits, multiple services provided to a patient may not be initiated by the physician or may not be a continuation of a service which began earlier in the day. An example of continuation of service is the time spent with a patient to review x-ray or laboratory results ordered during an examination of the patient earlier in the day. If the patient initiates the second and subsequent encounter(s) or the physician is requested to attend the patient by hospital or nursing home staff, additional encounters may be claimed

CODE	CONDITION	REMARKS
05	Second major exam (including consults) billed within a 90 day period. (Codes 101 to 106, 112, 113, 201 to 206, 212, 213, 301 to 306, 312, 313, 401 to 406, 412, 413)	This **second** major exam was necessitated by an emergency situation as per Payment Schedule
06	CT Scan of abdomen and pelvis reported by a Radiologist	CT Scan of abdomen and pelvis reported by Radiologist
07	Subsequent Hospital Visits billed by General Practitioners or Obstetrician/Gynaecologist prior to delivery (same admission)	Patient admitted prior to labour because of a complication of the pregnancy or because of a medical condition affecting or being affected by the pregnancy
08	Two anaesthetics given to patient this date either by this or another anaesthetist	The patient was under anaesthesia on two occasions on this date
09	Two separate operative sittings for this patient on this day	Patient had two separate operative sittings on this date
11	Caudal Epimorph	Caudal Epimorph
12	Multiple (two or more) single examinations (same fee code) reported on same day by a Radiologist or Nuclear Medicine Specialist	Each of these x-rays was a single examination, not different views and not comparison views
13	Multiple examinations (two or more) (different fee codes) reported on same day by a Radiologist or Nuclear Medicine Specialist	Each of these x-rays were requested by another physician or were found to be necessary by the Radiologist
14	Multiple (two or more) individual x-rays of areas normally covered by <u>one code for all</u> were necessary in this case and were done and reported by a Radiologist	Each individual x-ray was necessary and was reported as billed
15	Consult completed on the day <u>before</u> the patient was admitted to ICU. Claim is for the consult	This patient was not admitted to ICU until the next day
16	Scalp electrodes applied for fetal EKG and heart rate monitoring	This was a high risk pregnancy
17	Patient discharged from hospital and re-admitted same day or next. Claim is for the second admission	This patient was re-admitted on the same day or the day following discharge
18	Nerve blocks given for post-operative pain by an Anaesthetist	These nerve blocks were given for post-operative pain by an Anaesthetist
19	Time units for assistants or for Anaesthetists in excess of 20 units	The noted time was spent in continuous assist/ anaesthesia for this procedure
20	Visit not related to procedure	Visit not related to procedure
21	Visit made by a patient who is a WHSCC case but this particular visit is not for his/her WHSCC problem	Not for the WHSCC problem

CODE	CONDITION	REMARKS
22	Consult and follow-up care on an in-patient by a physician with specialty or sub-specialty in infectious diseases, but, attending physician maintaining responsibility for primary condition. Patient not transferred to infectious disease specialist	Primary condition treated by attending physician. This claim is for treatment of infectious disease
23	Patient bronchoscoped by a surgeon prior to induction of anaesthesia for thoracic surgery	Patient bronchoscoped before anaesthesia induced
24	Office, home, or out-patient visit made within the 42 day post-operative period after surgery because of **complications** necessitating the visit	Visit as a result of complications of a surgical procedure
25	Follow-up office, home, or out-patient visit to a patient who had surgery performed in a community which is **in excess of sixteen kilometers (ten miles)** from the community in which the follow-up treatment was rendered	Post-operative follow-up visit for a patient who has had surgery in a community which is more than sixteen kilometers from the visit location
26	Laser treatment of Port Wine Stain on face or neck by DOHCS approved surgeon	Port Wine Stain on Face or Neck
27	Laser treatment of Strawberry Hemangioma with complications by a DOHCS approved laser surgeon	Strawberry Hemangioma with Complications
28	Laser treatment of Blue Rubber Bleb Syndrome by DOHCS approved laser surgeon	Blue Rubber Bleb Syndrome
29	Laser treatment of Angiofibroma of Tuberous Schlerosis face or neck by a DOHCS approved laser surgeon	Angiofibroma of Tuberous Schlerosis face or neck
30	Laser treatment of Cherry Hemangioma with complications by a DOHCS approved laser surgeon	Cherry hemangioma with complications
31	Laser treatment of Hemangio-Lymphangioma with complications by a DOHCS approved laser surgeon	Hemangio-lymphangioma with complications
32	Laser treatment of Facial Telangiectasia Assoc. with Lupus, etc. by a DOHCS approved laser surgeon	Facial Telangiectasia Assoc. with Lupus, etc.

CODE	CONDITION	REMARKS
33	Laser treatment of Aterio-Venous Malformations over 18 years with complications by a DOHCS approved laser surgeon	Arterio-Venous Malformations over 18 years with complications
40	Rendered by an Anaesthetist outside of the Obstetrical Anaesthesia Block Funding Arrangement	Rendered outside of the Block Funding Arrangement
71	Resubmission of Previously Cancelled Item	Resubmission of Previously Cancelled Item

8.4.2 Diagnostic Codes

All claims submitted **must** contain a three digit diagnostic code based on the International Classification of Diseases (ICD-9) listing. These diagnostic codes are printed in a separate publication in both alphabetic and numerical sequence, and can also be found in Appendix 2—Diagnostic Codes of this manual. TeleClaim also includes a list of Diagnostic Codes.

8.4.3 Hospital Codes

Claims submitted for all services provided in hospital and long term care facilities **must** contain the number of the hospital/facility where the work was done; this applies to out-patient services as well as in-patient services. The four digit hospital/facility number must be entered on the claim in the space provided.

The rural hospital incentive payment to general practitioners is calculated based on the presence of the hospital number on claims submitted. Failure to include the hospital/facility number on claims for these services will result in the incentive **not** being paid for those services. Hospital/facility numbers are shown in Appendix 3—Hospital/Facility Codes in this manual.